

Charles Fleming Retirement Village Limited - Charles Fleming Retirement Village

Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Charles Fleming Retirement Village Limited
Premises audited:	Charles Fleming Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 26 May 2021 End date: 27 May 2021
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	122



Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Ryman Charles Fleming provides rest home, hospital and dementia level care for up to 120 residents in the care centre. There are also 20 serviced apartments certified for rest home level of care. On the day of audit there were 122 residents in total.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, relatives, management, staff and the general practitioner.

Ryman Healthcare has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and initiatives are set annually and have been fully implemented.

The village manager at Charles Fleming is non-clinical and has been in the role for 20 months. She is supported by a clinical manager who has been in the role for eight months and a resident services manager.

This certification audit did not identify any areas for improvement.

There are three areas of continuous improvement awarded for staff culture and communication, palliative care and infection control.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		All standards applicable to this service fully attained with some standards exceeded.
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Policies and procedures that adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) are in place. The welcome/information pack includes information about the Code. Residents and families are informed regarding the Code and staff receive ongoing training about the Code. The personal privacy and values of residents are respected. There is an established Māori health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and where appropriate their families, are involved in care decisions. Regular contact is maintained with families, including if a resident is involved in an incident or has a change in their current health. Families and friends can visit residents at times that meet their needs. There is an established system for the management of complaints.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Services are planned, coordinated and are appropriate to the needs of the residents. A village manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A comprehensive quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes. Residents receive appropriate services from suitably qualified staff. Human resources are managed in

accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training is in place, which includes in-service education and competency assessments. Registered nursing cover is provided twenty-four hours a day, seven days a week. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses, plans and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

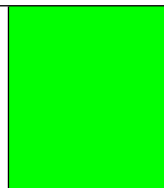
Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers are responsible for the administration of medicines. Medication charts are reviewed three-monthly by the GP.

The activities team implements the activity programme in each unit to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings and celebrations.

All meals and baking are done on site by qualified chefs. The menu provides choices and accommodates resident preferences and dislikes. Nutritious snacks are available 24 hours. Residents interviewed responded favourably to the food that was provided.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.



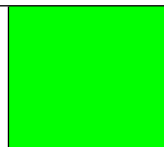
Standards applicable to this service fully attained.

The building has a current warrant of fitness. There is a preventative and planned maintenance schedule in place. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy with an ensuite. There are adequate numbers of communal toilets. There is sufficient space to allow the movement of residents around the facility. The hallways and communal areas were spacious and accessible. The outdoor areas were safe and easily accessible. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is a person on duty at all times with first aid training. Housekeeping staff maintain a clean and tidy environment. All laundry services are managed on site.

There is an approved fire evacuation scheme. There are six-monthly fire drills. Staff have attended emergency and disaster management training.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



Standards applicable to this service fully attained.

The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. At the time of the audit there were four hospital residents with restraints and no residents using an enabler. Assessments, consent forms and the use or risks associated with the restraint were evidenced. Staff training has been provided around restraint minimisation.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

All standards applicable to this service fully attained with some standards exceeded.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control officer (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control officer has attended external training. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service engages in benchmarking with other Ryman facilities.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	2	48	0	0	0	0	0
Criteria	3	98	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Ryman policies and procedures are being implemented that align with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information related to the Code is made available to residents and their families. Three managers (one village manager, one clinical manager and one regional manager) and seventeen care staff; including seven registered nurses (RNs), nine caregivers (three dementia, three hospital and three rest home) and three activities staff described how the Code is incorporated into their working environment. Staff receive training about the Code during their induction to the service. This training continues through the mandatory staff education and training programme.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices</p>	FA	<p>The service has in place a policy for informed consent. Completed resuscitation and general consent forms were evident on all eleven resident files reviewed (three rest home - including one serviced apartment resident, four hospital including one ACC funded respite resident and four from the dementia unit). Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney (EPOA) evidence is filed in the residents' charts. All residents in the dementia unit have activated EPOAs and a needs assessment confirms eligibility for secure level care.</p>

and give informed consent.		
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The residents' files include information on the resident's family/whānau and chosen social networks.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes included opportunities to attend events outside of the facility including activities of daily living. Interviews with staff, residents and relatives confirmed residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The organisational complaints policy is being implemented at Charles Fleming facility. The village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. The clinical manager and regional manager are involved in clinical complaints. The facility has an up-to-date complaint register for each unit. Concerns and complaints are discussed at relevant meetings. There have been 14 complaints made in 2020 and eight complaints received in 2021 year to date. Complaints have been acknowledged and addressed within the required timeframes. The Ministry requested follow up against aspects of a complaint that included quality and risk management systems – falls management and Assessment – falls assessment and documentation. There were no identified issues in respect of this complaint.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed	FA	There is a welcome pack that includes information about the Code. There is also the opportunity to discuss aspects of the Code during the admission process. Nine relatives (one rest home, four hospital and four dementia care) and five residents (three rest home, including one in the serviced apartments and two hospital care) stated they were provided with information on admission which included the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. The village manager reported having

of their rights.		an open-door policy and described discussing the information pack with residents/relatives on admission. Relatives and residents are informed of the scope of services and any liability for payment for items not included in the scope.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Ryman has policies that support resident privacy and confidentiality. A tour of the facility confirmed there are areas that support personal privacy for residents. During the audit, staff were observed being respectful of residents' privacy by knocking on doors prior to entering resident rooms and ensuring doors were closed while cares were being done. The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Residents' preferences are identified during the admission and care planning process with family involvement. Instructions are provided to residents on entry regarding responsibilities of personal belongings in their admission agreement. Caregivers interviewed described how choice is incorporated into resident cares. Staff attend education and training on abuse and neglect, last completed in April 2021.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	Ryman has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. The service has links with the local district health board (DHB) for advice and support as required. There was one resident who identified as Māori at the time of the audit. Cultural needs were addressed in the resident's care plan.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and	FA	An initial care planning meeting is carried out where the resident and/or family/whānau as appropriate are invited to be involved. Individual beliefs and values are discussed and incorporated into the care plan. Six-monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited and encouraged to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff take into account their values and beliefs.

respect their ethnic, cultural, spiritual values, and beliefs.		
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Staff job descriptions include responsibilities. The full facility meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with staff confirmed an awareness of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	<p>All Ryman facilities have a master copy of policies, which have been developed in line with current accepted best practice and these are reviewed regularly or at least three-yearly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies. A range of clinical indicator data are collected against each service level and reported through to Ryman Christchurch (formerly known as head office) for collating, monitoring and benchmarking between facilities.</p> <p>Indicators include resident incidents by type, resident infections by type, staff incidents or injuries by type and resident and relative satisfaction. Feedback is provided to staff via the various meetings as determined by the TeamRyman programme. Quality improvement plans (QIP) are developed where results do not meet expectations. An electronic resident care system is used by all sites to report relevant data through to Ryman Christchurch. The system of data analysis and trend reporting is designed to inform staff at the facility level. Management at facility level are then able to implement changes to practice based on the evidence provided.</p> <p>The service has been awarded a continuous improvement around palliative care provided to residents and their families.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective	FA	There is an incident reporting policy that guides staff to their responsibility to notify family of any resident accident/incident that occurs. Fourteen incident forms reviewed evidenced the family had been informed of the accident/incident. Relatives interviewed, stated that they are informed when their family members health status changes. Six monthly relative meetings occur in each of the units (rest home, hospital and dementia care). Residents interviewed, stated that they were welcomed on entry and were given time and explanation about the services and procedures. Specific introduction information is available on the dementia unit for family, friends and visitors visiting the unit. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Interpreter policy and contact details of interpreters is

communication.		available.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Charles Fleming is a Ryman healthcare village located in Waikanae. The service provides care for up to 120 residents at hospital, rest home and dementia level care and 20 serviced apartments certified for rest home level of care. On the day of audit there were 122 residents in total, 40 of 40 rest home residents on level one, 39 of 40 hospital level residents including two residents (ACC contract) on respite care on level two, 39 of 40 dementia care residents on level three. There were four rest home level of care residents in the serviced apartments at the time of the audit.</p> <p>Ryman Healthcare has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and initiatives are set annually. The organisation-wide objectives are translated at each Ryman service. Ryman Healthcare also has operations team objectives that include a number of interventions/actions. Each service also has their own specific village objectives 2021 and progress towards objectives is updated as part of the TeamRyman schedule.</p> <p>The village manager at Charles Fleming is non-clinical and has been in the role for 20 months. She is supported by a clinical manager who has been in the role for eight months (she worked previously at Ryman Rita Angus) and a resident services manager, who has been in the role for one year. The village manager is also supported by a regional operations manager (who was present at the time of the audit).</p> <p>The village manager has maintained over eight hours annually of professional development activities related to managing an aged care facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The clinical manager and resident services manager are responsible during the temporary absence of the village manager, with support from the regional operations manager and Ryman management team.</p>
Standard 1.2.3: Quality	FA	Charles Fleming service has a well-established quality and risk management programme that is directed by

<p>And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>Ryman Christchurch. Quality and risk performance is reported across the facility meetings (TeamRyman, full facility, clinical, health and safety infection control meetings) and reported to the organisation's management team. Discussions with the management team (village manager, resident services manager and clinical manager) and staff, and review of meeting minutes demonstrated their involvement in quality and risk activities. Annual resident and relative surveys are completed. Results and any areas for improvement are fed back to staff and participants through resident (two-monthly) and relative (six-monthly) meetings. There has been an increase in the resident's overall satisfaction average score from the previous year from 4.52 to 4.60 and the relatives' overall satisfaction rate from the previous year from 3.98 to 4.56. Corrective actions have been established around food satisfaction, care and communication.</p> <p>The service has policies, procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The quality monitoring programme is designed to monitor contractual and standards compliance and the quality-of-service delivery. Management systems have been implemented and regularly reviewed including an internal audit programme. Quality improvement plans are implemented for audit outcomes less than 90%. Re-audits are completed as required. The facility has implemented processes to collect, analyse and evaluate data including infection control, accidents/incidents, complaints which are utilised for service improvements. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed.</p> <p>Health and safety policies are implemented and monitored by the combined monthly health and safety and infection control meetings. The health and safety officer (caregiver) was interviewed. She has completed level one external health and safety training. Health and safety meetings are conducted bi-monthly. Risk management, hazard control and emergency policies and procedures are in place. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The hazard identification resolution plan is sent to head office and identifies any new hazards. A review of the risk register indicated that there is resolution of issues identified.</p> <p>Falls prevention strategies are in place that include; ongoing falls assessment, reviewing call bell response times and routine checks of all residents specific to each resident's needs. All falls are fully investigated, medical causes identified and treated, location and timing of falls analysed for trends and ongoing education includes manual handling, hoist refreshers, intentional rounding and use of equipment such as sensor mats, physiotherapy input and encouragement in exercise programmes. Case studies are discussed at clinical meetings. General practitioners are notified of falls and a medical review including medication review is completed. Care plans record falls prevention strategies that reflect the residents falls risk. Falls prevention and management training has recently been held at a full facility meeting in April 2021 for all staff to attend.</p>
Standard 1.2.4: Adverse	FA	There is an incident reporting policy that includes definitions and outlines responsibilities including immediate

<p>Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted and any follow-up action required. A review of 14 incident/accident forms for April 2021 from across all areas of the service, identified they all are fully completed, including follow-up by a registered nurse (RN) and relative notification. Post falls assessments included neurological observations for six unwitnessed falls with potential head injuries. The clinical manager is involved in the adverse event process, with links to the applicable meetings (TeamRyman, full facility, clinical, health and safety/infection control). This provides the opportunity to review any incidents as they occur.</p> <p>The village manager and clinical manager were able to identify situations that would be reported to statutory authorities. There has been four section 31 notifications made since the last audit for a dementia resident related police investigation, two dementia resident challenging behaviours and one unstageable pressure injury.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources policies including recruitment, selection, orientation and staff training and development. Eight staff files reviewed (one clinical manager, two-unit coordinators, one RN, three caregivers including the health and safety officer and one head chef) provided evidence of signed contracts, job descriptions relevant to the role, induction, reference checks and annual performance appraisals. A register of RN, EN and health professional practising certificates are maintained and current. An orientation/induction programme provides new staff with relevant information for safe work practice. There is a completed annual education plan for 2020 and the plan for 2021 is being implemented. The annual training programme exceeds eight hours annually. Additional toolbox sessions are provided.</p> <p>Communication folders in each unit contain education content for staff to read and sign if they have not attended the education session. Staff are also required to complete a series of comprehension surveys each year. Registered nurses are supported to maintain their professional competency. There is regular RN journal club. All RNs, management team and activities persons hold a current first aid certificate. There are implemented competencies for RNs, ENs and caregivers related to specialised procedures or treatments including medication competencies and insulin competencies. Caregivers are encouraged to gain qualifications with the New Zealand Qualification Authority (NZQA). There are 22 RNs working at Charles Fleming and 18 RNs have completed interRAI training. Fifteen caregivers work in the dementia unit, all 15 caregivers have completed their dementia standards.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and</p>	FA	<p>Ryman organisational policy outlines on call requirements, skill mix, staffing ratios and rostering for facilities. There is a pool of casual staff to cover unplanned absences. A plan of action document is available for staff around any weekly staff changes. The village manager works Monday to Friday and the clinical manager works Sunday to Thursday. Both are on call 24/7 for any operational and clinical issues respectively. They are</p>

<p>safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>supported by three-unit coordinators/RN in the rest home, hospital and dementia units and one unit coordinator/enrolled nurse (EN) in the serviced apartments.</p> <p>Staffing at Charles Fleming is as follows; in the rest home unit there are 40 of 40 residents, there is a unit coordinator who is supported by an RN on the morning shift. There are four caregivers (two full and two short-shifts) on the morning and afternoon shifts and two caregivers on night shift. In the hospital unit there are 39 of 40 residents, there is a unit coordinator who is supported by two RNs on duty on the morning and afternoon shifts, and one RN on night shift. There are eight caregivers (four full and four short-shifts) and a fluids assistant on morning shift, six caregivers (two full and four short-shifts) and a lounge carer on afternoons and three caregivers on night shift.</p> <p>In the dementia care units, there are 39 of 40 residents across the 2x 20 bed units. There is a unit coordinator who is supported by an RN on duty on the morning and afternoon shifts covering both units. There are two caregivers (one full and one short-shift) and a lounge carer in each unit on the morning and afternoon shifts and two caregivers in each unit on the night shift (an additional caregiver floats between both units).</p> <p>The hospital RN covers the rest home unit on the afternoon and night shifts and the dementia unit on the night shift.</p> <p>In the 20 serviced apartments there are four rest home level residents, there is a unit coordinator/EN on the morning shift from Sunday to Tuesday and a senior caregiver from Friday and Saturday. There are two caregivers on the morning and afternoon shifts. Caregivers from the rest home cover the serviced apartments on the night shift.</p> <p>Activities are provided seven days a week for all residents in the care centre. A registered physiotherapist is available three days a week totalling 15 hours. There are separate laundry and cleaning staff.</p> <p>Staff on the floor on the days of the audit were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Seven caregivers interviewed (two hospital, two rest home, two dementia care and one serviced apartment) stated the RNs are supportive and approachable. Interviews with residents and relatives indicated there overall there are sufficient staff to meet resident needs.</p>
<p>Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and</p>	<p>FA</p>	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Entries are legible, dated and signed by the relevant care assistant or registered nurse including designation. Individual resident files demonstrate service integration.</p>

accessible when required.		
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are implemented policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry including information on the 48-hour complimentary service for village residents, short-term stays, rest home, hospital and dementia level of care services. The admission agreements reviewed met the requirements of the ARRC contract. Exclusions from the service are included in the admission agreement. All long-term admission agreements including the one short-stay admission agreement for an ACC funded respite care resident were signed and dated.</p> <p>The clinical manager described the admission process including the service reviewing all admissions and discussing the admission with the family and resident prior to admission.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Policy describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. Communication with family occurs.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. Registered nurse and senior caregivers have completed annual medication competencies and education. Registered nurses have completed syringe driver training. Medications are stored safely in all units (the hospital unit, rest home, serviced apartments and dementia care units). All regular medications (blister packs) are checked on delivery by RNs against the electronic medication chart. A bulk supply order is maintained for hospital level residents. All medications were within the expiry dates. Eyedrops and ointments are dated on opening. The medication fridges are checked weekly, and temperatures sighted were within the acceptable range. There were three rest home residents and one hospital level resident self-medicating on the day of audit. Medications are stored safely in the resident's room. Three monthly self-medication competencies had been completed by the RN and authorised by the GP. There were no standing orders.</p> <p>Twenty-two medication charts on the electronic medication system were reviewed, including the respite resident's medication file. Medications are reviewed at least three- monthly by the GP. The GP and the community mental health nurse review medications for dementia care residents. There was photo identification</p>

		and allergy status recorded. 'As required' medications had indications for use prescribed. The effectiveness of 'as required' medications is recorded in the progress notes and on the electronic medication system. Medication administration observed complied with policy.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The head chef oversees the procurement of the food and management of the kitchen and staff. All kitchen staff have current food safety certificates. The food control plan expires July 2021. There is a well-equipped kitchen, and all meals are cooked on site. Special equipment such as lipped plates are available. On the day of audit meals were observed to be hot and well-presented and residents stated that they were enjoying their meal. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded weekly. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted in a folder and on a whiteboard. There are snacks available at all times in the dementia unit. The four-weekly menu cycle is approved by a dietitian. All residents and family members interviewed were very satisfied with the meals. Residents have the opportunity to feedback on the service through resident meetings and surveys. Management liaises regularly with the head chef to monitor feedback and identify any areas for improvement.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to prospective residents should this occur and communicates this to prospective residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment Consumers' needs,</p>	FA	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Initial assessments had been completed on the VCare system within 24-48 hours of admission for all residents entering the service including short-stay residents and residents admitted under the 48-hour complimentary service (as viewed in a previous file).</p>

<p>support requirements, and preferences are gathered and recorded in a timely manner.</p>		<p>InterRAI assessments had been completed for all long-term residents. Applicable VCare assessments are completed and reviewed at least six monthly or when there is a change to residents' health/risk. The outcomes from all assessments is reflected in the myRyman care plan. Behaviour assessments had been completed for the files of four dementia care residents with the outcomes included in the care plan.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans reviewed were resident centred. Interventions documented support needs, resident goals and provided detail to guide care. There was a behaviour management plan in the files of dementia care residents that included interventions and strategies for de-escalation including activities. MyRyman care plans reviewed have been updated when there were changes to health, risk, infections or monitoring requirements. Residents and relatives interviewed stated that they were involved in the care planning process with the RNs. There was evidence of service integration with documented input from a range of specialist care professionals including the physiotherapist, hospice nurse, dietitian, district nurse, wound care nurse and mental health services for older people. The care staff interviewed advised that the myRyman care plans were easy to access and follow.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition changes the registered nurse initiates a GP or nurse specialist consultation. A registered nurse interviewed stated that they notify family members about any changes in their relative's health status. Family members interviewed confirmed they are notified of any changes to health of their relative. Communication and relative notifications are recorded in the electronic progress notes. All care plans reviewed had interventions documented to meet the needs of the resident. Care plans have been updated as residents' needs changed.</p> <p>The myRyman electronic system triggers alerts to staff when monitoring interventions are required. These are automatically generated on the electronic daily schedule for the caregiver to complete. Individual surface devices in each resident room allows the caregiver the opportunity to sign the task has been completed, (e.g., resident turns, fluids given).</p> <p>Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Wound assessments and management plans are completed on myRyman. When wounds are due to be dressed a task is automated on the RN daily schedule. Wound assessment, wound management, evaluation forms, and wound monitoring occurs as planned in the sample of wounds reviewed. There were seven wounds registered in the rest home with no pressure injuries. There were 15 documented wounds in the hospital, three residents had six wounds between them. There were no residents with pressure injuries. There were seven residents with wounds in the dementia unit, one resident had three pressure injuries; including one unstageable</p>

		<p>for which a section 31 was evidenced.</p> <p>All residents with wounds documented at least a monthly review as well as scheduled, ongoing wound evaluations as part of routine wound care. There has been input from the GP and wound care nurse specialist as required. Photos of wounds demonstrated healing progress. Pressure injury prevention equipment is available and is being used. Caregivers document changes of position electronically. Wound care training has been provided in May as part of the RN journal club. The wound care RN stated that the service focus is on reducing skin tears, through good skin care and manual handling training for staff.</p> <p>Short-term care plans are generated through completing an updated assessment on myRyman, and interventions are automatically updated into the care plan. Evaluations of the assessment when resolved closes out the short-term care plan.</p> <p>Electronic monitoring forms are in use as applicable such as weight, food and fluid, vital signs, blood sugar levels, neurological observations, wound monitoring and behaviour charts. The RNs review the monitoring charts daily.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activity team and lounge carers implement the Engage activities programme in each unit that reflects the physical and cognitive abilities of the resident groups. The team includes two qualified diversional therapists and four activity staff for the rest home, hospital and the dementia unit as well as two further activity staff for the serviced apartments. There is also a van driver. The rest home programme is Monday to Friday and the hospital and dementia units are seven days a week. There is an activity person in the dementia unit until 8 pm in the evening who, with the care staff, ensures that activities and support are always available to the residents.</p> <p>There is a monthly programme for each unit in large print on noticeboards and some residents also have a copy in their rooms. Residents have the choice of a variety of engage activities in which to participate including (but not limited to) triple A exercises, board games, quizzes, music, reminiscing, sensory activities, crafts and walks outside. The rest home residents in serviced apartments can choose to attend the serviced apartment or rest home activity programme. Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat. The service has three vans, including one with a lift for hospital level residents. There are regular combined activities and celebrations held in the large lounges and atrium for residents from all the units. Dementia care residents (as appropriate) join in the rest home/hospital activities for entertainment and other celebrations under supervision.</p> <p>Activities in the dementia care units include triple A exercises, garden walks in the two courtyards and around the village, singing, happy hours, hand therapy, word games, knitting group and dancing. Resources are plentiful. Cultural groups and pet therapy visit (to all units).</p> <p>There are interdenominational church services held in the chapel with room visits as required. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Father's Day, Anzac Day and Christmas</p>

		<p>and theme days are celebrated. Junior school children and kapa haka groups visit.</p> <p>Residents have an activity assessment (life experiences) completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the activity plan (incorporated into the myRyman care plan) is based on this assessment. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan. Residents have the opportunity to provide feedback through resident and relative meetings and annual surveys. Residents and relatives interviewed expressed satisfaction with the activities offered.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The ten long-term resident care plans reviewed had been evaluated by the registered nurses six monthly or when changes to care occurs. The respite care resident file documented reviews and updates to care as needed. The RN completes a daily evaluation for respite residents. The multidisciplinary review involves the RN, GP, caregiver and resident/family if they wish to attend. Activities plans are evaluated at the same time as the care plan. There are one-three monthly reviews by the GP for all residents. Family members interviewed confirmed that they are informed of any changes to the care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the wound care nurse specialist, geriatrician, mental health services for older people, dermatology and dietitian. Discussion with the registered nurses identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are</p>	FA	<p>There were implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles were available, and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals were labelled correctly and stored safely throughout the facility. Safety datasheets and product use information was readily available. Relevant staff have attended chemical safety training.</p>

protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.		
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current building warrant of fitness that expires March 2022. The building is three levels with lifts and stairs between floors.</p> <p>The service employs a full-time head of maintenance person who attends health and safety committee meetings. The maintenance person ensures daily maintenance requests are addressed. A 12-monthly planned maintenance schedule is maintained. Essential contractors are available 24 hours. Electrical testing is completed annually. Annual calibration and functional checks of medical equipment is completed by an external contractor. Hot water temperatures in resident areas are monitored three-monthly, as part of the environmental audit. Temperature recordings reviewed were maintained below 43-45 degrees Celsius.</p> <p>The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. Residents were observed to safely access the outdoor gardens and courtyards. Seating and shade is provided.</p> <p>Each dementia care unit has an outdoor balcony with seating, shade and raised gardens. There are safe walking pathways out of both units and residents can enter either unit.</p> <p>The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene</p>	FA	<p>All bedrooms are single occupancy and have a full ensuite. There were communal toilets located close to the communal areas. Toilets have privacy locks. Residents interviewed confirmed their privacy was assured when staff were undertaking personal cares.</p>

requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	All resident's rooms were of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility and transferring aids such as hoists. Residents are encouraged to personalise their bedrooms. Serviced apartments also have a lounge area.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	The care centre has the rest home wing on the first floor, the hospital floor on the second floor; however both floors are dual-purpose. There are two dementia care units on the third floor with a shared nurse's station between. The rest home and hospital have a large main lounge, smaller library lounge and a family room for visitors with tea making facilities. The large main lounges have seating placed to allow for individual or group activities. The rest home and hospital have a separate dining room from the lounge. Each dementia care unit has an open plan lounge and dining room with a safe kitchenette area. There are seating alcoves with items of memorabilia. There are accessible communal lounges for residents in apartments.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>The external chemical provider monitors the effectiveness of chemicals in the cleaning and laundry service. Laundry and cleaning audits were completed as per the Ryman programme. The laundry had an entry and exit door with defined clean/dirty areas.</p> <p>There are dedicated cleaning and laundry persons on duty each day. All linen and personal clothing is laundered on site. Residents interviewed stated they were happy with the cleanliness of their bedrooms and communal areas. Residents confirmed their clothing was treated with care and returned to them in a timely manner. Cleaning trolleys are kept in locked designated areas when not in use.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely</p>	FA	There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Staff have attended emergency and disaster management training. The facility has an approved fire evacuation scheme in place and fire drills take place six-monthly. The last fire evacuation drill occurred on 21 April 2021. Smoke alarms, sprinkler system and exit signs are in place. There are staff employed across the facility 24/7 with a current first aid certificate. There are first aid kits located at reception, kitchen, facility van and maintenance

<p>response during emergency and security situations.</p>		<p>shed. Battery operated emergency lighting is in place which runs for at least four hours. The facility has an on-site diesel generator to run essential services.</p> <p>There is a civil defence kit located on each level which are checked monthly. Supplies of stored drinkable water is stored in large holding tanks (31,000 litres). There is sufficient water stored to ensure 20 litres per day for seven days per resident. There are alternative cooking facilities available with two gas barbeques and two gas burners. There is an effective call bell system in all bedrooms, ensuites and communal areas. The call bells and door alarms are linked to pagers carried by staff. Calls light up on the main call panel in the nurse's station. Staff advise that they conduct security checks at night, in addition to an external contractor. A security camera is installed at the entrance. The facility is secure after hours.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>General living areas and resident rooms are appropriately ventilated and heated with underfloor heating. All resident rooms and communal areas have external windows with plenty of natural sunlight.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The infection prevention and control programme is appropriate for the size and complexity of the service. The infection control and prevention officer is a registered nurse based in the hospital. A job description defines the role and responsibilities for infection control. The infection prevention and control committee are combined with the health and safety committee, which meets two-monthly. The programme is set out annually from head office and directed via the quality programme. The programme is reviewed annually as part of the Ryman training day for infection control officers.</p> <p>Visitors are asked not to visit if they are unwell. Residents and staff are offered the annual influenza vaccine. Hand sanitisers are placed appropriately within the facility.</p>
<p>Standard 3.2: Implementing the infection control programme</p>	<p>FA</p>	<p>The infection prevention and control committee (combined with the health and safety committee) meet two-monthly. The infection control officer is allocated four hours per month to collate infection rates and provide reports to the committee, management and facility meetings including trends and analysis of infections. The infection and prevention officers have access to an infection prevention and control nurse specialist from the</p>

<p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>		<p>DHB, infection control consultant, microbiologist, public health, GPs, local laboratory and expertise from within the organisation.</p> <p>Ryman Covid-19 strategies have been implemented within the facility. There are robust processes documented, with monthly drills to ensure staff awareness is always up to date. There are plentiful supplies of PPE.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>There are comprehensive infection prevention and control policies that are current and reflected the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. These policies are generic to Ryman and the policies have been referenced to policies developed by an infection control consultant. Infection prevention and control policies link to other documentation and cross reference where appropriate.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control officer is responsible for coordinating/providing education and training to all staff, and she has attended external training for her role. The orientation/induction package includes specific training around hand hygiene, standard precautions and outbreak management training is provided both at orientation and as part of the annual training schedule. All staff complete hand hygiene audits and education annually. Infection control is an agenda item on the full facility and clinical meeting agenda. There is monthly 'outbreak drills' to ensure staff are fully aware of protocols should an outbreak occur.</p> <p>Resident education occurs as part of providing daily cares. Care plans include ways to assist staff in ensuring this occurs.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>CI</p>	<p>The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections are appropriate to the complexity of service provided. Individual infection report forms are completed on the VCare system for all infections and are kept as part of the on-line resident files. Infections are included on an electronic register and the infection control and prevention officer completes a monthly report identifying any trends/analysis and corrective actions. Monthly data is reported to the combined infection prevention and control/health and safety meetings. Staff are informed of infection control through the variety of facility meetings and graphs are displayed.</p> <p>The infection prevention and control programme links with the quality programme including internal audits. Systems in place are appropriate to the size and complexity of the facility. The results of surveillance are used to identify trends, identify any areas for improvement and education needs within the facility.</p> <p>There have been no outbreaks since the last audit.</p> <p>The service has been awarded a continuous improvement for the reduction of urinary tract infections and antibiotic stewardship.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. At the time of the audit there were four hospital residents with restraints (one bed rail and three chair briefs) and no residents using an enabler. Staff training has been provided around restraint minimisation, last completed in October 2020.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and</p>	<p>FA</p>	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (hospital unit coordinator) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.</p>

others.		
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator in partnership with the RNs, GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and family/whānau are evident. The files of the four hospital residents using restraint were reviewed. The completed assessments considered those listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. Restraint authorisation is in consultation/partnership with the resident, family and the GP. The use of restraint is linked to the resident's restraint care plan, evidenced in the four resident files reviewed. An internal restraint audit, conducted six-monthly, monitors staff compliance in following restraint procedures.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted three-monthly and include family, evidenced in the four resident files reviewed where restraint was in use.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint minimisation programme is discussed and reviewed at a national level and includes identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff education and training programme.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

No data to display

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>There service has implemented a robust process to provide excellence in care to palliative care residents and their families. The process includes early interventions and close liaison with specialist palliative care nurses. Families have documented in surveys that the care has been excellent “because of the small details” and how well both the resident and</p>	<p>The service has created a palliative care champion nurse (RN). The palliative care champion leads three-monthly meetings to review palliative care provided and set expectations for future care. Meetings were viewed as part of the audit. The meetings have as their philosophy ‘to lead from the heart’ and families interviewed noted that the care is very caring and supportive (not just for palliative). The palliative care team at Charles Fleming have all documented a validatory story as to why they are a committed team member and have all undertaken additional training (counselling training and palliative care nursing training as examples). Recourses have been purchased to assist in end-of-life care and comfort such as candles, luxury skin care products and a bible as examples. Family support includes a snack trolley provided at all times as well as meals and the Ryman end of life information book. The palliative nurse champion explained that the palliative nurse specialists are always closely involved in care and support and the service also extends it to family care to support the family post death along with the hospice team. Family feedback via compliments in the folder and Ryman twitter has been very complimentary of the care and commitment of the services and the care team.</p>

		the family were looked after.	
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>	CI	<p>A quality improvement plan (QIP) was implemented in September 2019 to improve staff engagement and satisfaction for residents in the service being delivered. Poor culture within staff resulted in ongoing sick leave, roster issues and difficulty in recruiting staff which had an overall impact on the quality of service being provided to the residents.</p>	<p>The goal was for Charles Fleming to be a place of choice for work in the Kapiti Coast region. The action plan included having a healthy staff roster, appropriate staff skill mix, including the right person for the right job, weekly roster meetings with the leadership team, positive communication and feedback given to staff on a regular basis and monthly staff appreciation awards.</p> <p>During the Covid-19 period, the management team reviewed options for an improved means of communication with staff so implemented the social media “ChattR” channel. Leaders were encouraged to touch base with staff on a weekly basis, asking how they were, how were things at home, checking to see if there was any extra support required. Special Covid-19 leave was instigated by the company, so staff did not have to use their own leave. Staff were paid extra per hour during the level 4 lockdown. Vulnerable staff continued to be paid throughout the whole pandemic period.</p> <p>Staff continue to be encouraged not to come to work if they are unwell. Additional sick leave was provided, so staff feel secure not coming to work if they are unwell, and have no sick leave left. Staff were provided with wellness journals to document healthy diet and exercise daily, and smoke free packs and support have been offered to staff. Each staff member has been allocated a wellness day. The ChattR Channel has been well received by staff. The channel is used by managers to remind staff of competencies, education, any changes and reminders to staff.</p> <p>There has been an increase in the staff satisfaction survey with the net promoter score for staff detractors decreasing from 56% in 2019 to 22% in 2020. The relative survey in April 2020 also demonstrated an increase in resident’s satisfaction of the service being delivered. All staff interviewed stated they ‘loved’ working at Charles Fleming, they felt appreciated and felt they had a good team.</p>
<p>Criterion 3.5.7</p> <p>Results of surveillance,</p>	CI	<p>Meeting minutes include identifying trends, corrective</p>	<p>The service has been working with the GP service with regard to antibiotic stewardship. The prescribing of antibiotics has reduced for hospital level residents. January 2021 documented 20 antibiotics prescribed for twelve</p>

<p>conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>		<p>actions and evaluations of quality improvements. Monthly and annual comparisons for infections are made and graphed which are displayed for staff. The service is benchmarked against other organisational facilities.</p>	<p>residents, and May documented ten antibiotics for eight residents. Regular review of all residents along with pharmacy input has enabled this downward trend and also ensured regular evaluation and review of antibiotic use.</p> <p>The service has reduced urinary tract infections. It was identified that there was an opportunity to reduce the incidence of urinary tract infections for rest home level care residents. An action plan was implemented. The action plan included a review of best practice and eliminating the routine use of dip-sticks. A process was implemented to increase fluid intake for residents, toileting rounds (as needed) as part of intentional rounding, and unit coordinator oversight for residents identified as at risk of not drinking enough. Additional staff training was provided around infection control and urinary tract infections. The programme was reviewed through monthly meetings and six-monthly clinical indicator reports. Since June 2020 urinary tract infections have reduced from 2.67 for 1000 occupied bed days to zero December 2020. A review of trend since December evidence continued low rates; less than one per 1000 occupied bed days.</p>
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End of the report.